RPI Registration Form

E-mail address:				**Would you like to sign up for our newsletter? Yes No**		
Today's date:	**Referring Physician:**			**Onset Date of Symptoms:**		

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)	
					Single / Mar / Div / Sep / Wid	
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes ❑ No			/ /		❑ M	❑ F
Street address:		Social Security no.:		Home phone no.:		
				( )		
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.:				
		( )				
Chose clinic because/Referred to clinic by (please check one box and give name so we may Thank them)	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						
Is this injury work related? Yes No	**Is this injury related to a MOTOR VEHICLE ACCIDENT? Yes No**					

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
	/ /		( )		
Is this person a patient here?	❑ Yes ❑ No				
Occupation:	Employer:	Employer address:	Employer phone no.:		
			( )		
Is this patient covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance:					
❑ Attorney Name:	❑ Attorney Phone:	❑ Attorney Address:	❑ Work Comp Carrier:	❑ Claim Number:	Adjuster Name & Number:

Subscriber's name:	**Subscriber's S.S. no:**	**Birth date:**	**Group #:**	**Policy #:**	Referral Needed?
		/ /			

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to RPI. I understand that I am financially responsible for any unpaid balance. Any unpaid balance is subject to a collection agency for nonpayment. I understand I am required to pay all collection costs and attorney fees to the extent limited by law. I authorize you to release my insurance company or its agent, information concerning health care, advice, treatment or supplies provided to me- This information will be used for the purpose of evaluating and administering claim benefits. **This office reserves the right to charge $30.00 for missed appointments.**

Patient/Guardian signature		**Date**	